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Calcareous Pancreatitis And Diabetes

THE REPORT OF A CASE

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Chronic pancreatitis is the term used to describe varying degrees of acquired fibrosis of the pancreas with increase of the interstitial connective tissue more or less replacing the parenchyma of the gland. Two types of pancreatitis were described by Opie.[1] The first of these is the interlobular type in which the increased fibrous tissue is limited to the tissues between the lobes of the parenchyma and in which diabetes is said to be very rare. The second is the interacinar type in which the connective tissue invades the interacinar spaces with progressively advancing sclerosis, replacement of the parenchyma, and destruction of the isles of Langerhans late in the process. Advanced fibrosis of this type is frequently associated with diabetes mellitus. Chronic pancreatitis is not an uncommon incidental finding at autopsy or surgery in elderly patients, but is rarely diagnosed or suspected in the living patient.

Deposition of calcium salts in the substance of the pancreas is rarely encountered. Pancreatic calculi were first described in Europe by de Graff in 1667. By 1942 two hundred and fifty cases of true pancreatic lithiasis had been reported in the literature.[2] Recent case reports by others bring this total to 285.[3-11]

Two types of pancreatic stones were described by Mayo.[1,2] These are the (a) true stones found in the pancreatic ducts and (b) false stones or calcifications of the parenchyma resulting from pancreatitis. The first type may be the cause of colickly pain and surgical intervention may be sought. The second type is not in itself a cause of pain and is less often diagnosed. Dozzi and Bockus[2] in 1943 found reports of 18 cases of diffus calcareous pancreatitis. The recent case reviews of chronic relapsing pancreatitis from the larger clinics[9-11] suggest that clearcut differentiation between duct stones and diffuse calcification of the parenchyma is not of clinical significance in the diagnosis of the primary disease, but in reality, are both manifestations of chronic recurrent pancreatic inflammation.

Another patient exhibiting diffuse calcification of his pancreas accompanied by diabetes mellitus, steatorrhea and transient jaundice has been recently studied at Roper Hospital. Because of the seeming rarity of this syndrome it is believed worthwhile to publish the observations made in this patient in some detail.

Case Report

Mr. H. C., a 43 year old white male was admitted to Roper Hospital because of weakness and glycosuria on 26 September, 1946.

Four months prior to admission the patient had been hospitalized elsewhere for treatment with symptoms of chills and fever, acute generalized abdominal pain which was most severe in the left upper quadrant, mid-epigastrium, and left costovertebral angle, nausea and vomiting. Jaundice appeared in the second week of his illness. He was treated with quinine and glucose infusions and was told he had sugar in his urine as a result of the infusions. After 15 days of hospitalization he was discharged. He continued to feel weak and continued to lose weight. At the time of admission he found that he had lost 32 pounds in 56 days. For three weeks prior to admission polyuria and pdydipsia had been present. Glucose was found in the patient's urine on routine urinalysis in the outpatient clinic and he was admitted for study.

The patient was a leadburner. There was no known contact with tuberculosis and no relative was known

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to have diabetes. He gave a past history of mumps, pleurisy, and malaria in 1928. He had been edentulous since 1937. For many years he had suffered pyrosis, often relieved by eructating, after meals and at night. He had seldom vomited and prior to his present illness had never had abdominal pain. His bowel habits and stools had been normal. Before the onset of his present illness he usually drank about 1 pint of whiskey daily.

Physical examination showed a white male of 5 feet 8 inches height and 119 pounds weight, with a temperature of 99.6° F., a pulse of 88, respiratory rate of 20, and a blood pressure of 124/90. He appeared chronically ill, weak, and showed evidence of weight loss. There was no icterus of the skin or sclerae. All teeth had been extracted and replaced by plates. The axillary lymph nodes were palpable but not enlarged. The lungs were clear to percussion and ausculation. The heart was not enlarged and there were no arrhythmias or murmurs. The abdominal wall was flat and relaxed with no palpable masses, organs, or evident tenderness. There was no costo-vertebral angle tenderness. The genitalia were normal and rectal examination revealed a normal prostate and rectal pouch.

Laboratory data: The urine showed a 4 plus reaction for sugar and a negative reaction for acetone. The blood erythrocyte count was 4,800,000, the hemoglobin 12.0 gms. The white blood count was 8,500 with a differential count of 55% polymorphonuclears, 35% lymphocytes, 5% monocytes, 2% eosinophiles, and 3% basophiles. The fasting blood sugar was 298 mgm %; the blood urea nitrogen 23 mgm %, the icterus index 4. A blood smear for plasmodia was negative and no basophilic stippling of the red cells was noted. Serum agglutinations for the common febrile diseases were not diagnostic. The Wassermann and Kline tests were negative. The stools were clay-colored, slightly greasy, and revealed on microscopic examination the presence of an unusual quantity of fat globules.

A plain film of the abdomen revealed a large number of small rounded calcific densities arching across the upper abdomen interpreted by the radiologist as probable calcifications in the pancreas.

On direct and repeated questioning the patient again denied any change in bowel habits, but questioning of his wife revealed that for at least 4 years the patient had frequently had diarrhea of copious, fatty stools; that he was unable to control his oily bowel movements and would pass greasy fecal material in his underwear or in bed. She stated that his stools were so laden with oil that the toilet bowl had to be cleaned with lye and that the water in the bowl was covered by a layer of oil droplets following the passage of a stool. She volunteered the information that the patient had consumed during the four years of their marriage "as much alcohol as a man could take." His alcoholic bouts were always followed by increased steatorrhea.

A gall bladder x-ray examination showed impaired function manifested by failure to empty after a fat meal. The gall bladder was empty 24 hours later.

A barium meal aided in localizing the calcification throughout the length of the pancreas and revealed no evidence of peptic ulcer, inflammation or malignancy of the esophagus, stomach or duodenum.

The serum amylase was 16 and 32 units per 100 cc. on two determinations. The serum cholesterol was 156 mgm. %, calcium 9.1% mgm., phosphorus 4.8 mgm. %, total protein 7.48 gms., albumin 5.29 gms., globulin 2.19 gms.

Duodenal suction with a Miller-Abbott tube was attempted. The tube was seen on fluoroscopy to be lying in the second portion of the duodenum but all of the specimen obtained was of high free acidity, not bile stained, and no pancreatic amylase was found on titration. The patient would not permit passage of the tube a second time.

Course In The Hospital:

The patient's diabetes was controlled on a diet of relatively low fat content. An insulin mixture of 10 units of protamine zinc insulin and 20 units of regular insulin was given once daily before breakfast. On this regime his steatorrhea was well controlled and he was discharged 63 days after admission with a weight gain of 5 pounds.

The patient has been followed in the out-patient clinic for more than a year. He continued to gain weight until he had returned to his usual weight of 150 pounds. After 8 months he was able to keep his urine sugar free by diet alone and with careful regulation of his fat intake was able to minimize the steatorrhea. Insulin was not necessary for five months. Then his work required him to move to a nearby town where his diet was not well managed and he again began to drink moderately. Insulin has since been necessary to keep him regulated.

Discussion

The following diseases associated with chronic pancreatitis are listed by most authors: Chronic alcoholism, chronic disease of the biliary system, occlusion of the main pancreatic duct by calculus or carcinoma, arteriosclerosis, gastritis, duodenal ulcer, duodenitis, acute pancreatitis, syphilis and tuberculosis.

Supposedly most important in the pathogenesis of chronic pancreatitis are alcoholism and longstanding infection of the biliary tree. Infection is believed to extend to the pancreas by way of the pancreatic lymphatics. Approximately two thirds of the patients with pancreatitis have cholelithiasis and one fourth of the patients with gall bladder disease have some pancreatitis.[2] Of 36 autopsies on patients with chronic pancreatitis at the Boston City Hospital, 12 had chronic cholesystitis and 7 had cholelithiasis.[13]

The series of patients reported by Comfort, et al,[9] had chronic pancreatitis associated with no other disease of the gastrointestinal tract.

The percentage of chronic alcoholics among patients with acute and chronic pancreatitis and pancreatic lithiasis reported in the literature is strikingly high. Clark,[14] reported in 1942, a series of 36 autopsies in alcoholic patients with pancreatitis none of whom had gall bladder disease. He concludes that the role of the prolonged alcoholic debauch overshadows, by far, that of chronic gall bladder disease, in the pathogenesis of pancreatitis. At any rate, it is well known that chronic alcoholics are unusually susceptable to disease of the organs of the upper gastrointestinal tract. Alcohol seemed of little importance, however, in the development of chronic pancreatitis in a series of patients with this disease reviewed in January, 1948 by Maimon, et al. Only 2 of their patients would admit to chronic alcoholism.[11]

The majority of patients with chronic pancreatitis are between the ages of 40 and 50 years and the incidence in males is higher than females, despite the greater incidence of gall bladder disease in females.

There is no clear-cut symptom complex in chronic pancreatitis and it is for this reason that the disease is confused with other conditions. There may be intermittent seizures of pain in the epigastrium lasting for hours or days with radiation to the back or between the scapulae. The pain is sometimes exceedingly severe and may be taken for gall bladder colic. Dyspepsia with bloating and belching is frequently a complaint. Steatorrhea of varying severity may be present with production of large, foul-smelling, pale, glistening, greasy or oily stools of acid reaction and with microscopic evidence of increased undigested muscle fiber. There is usually fairly marked weight loss. Jaundice is absent in most cases but a history of intermittent jaundice may be obtained. A slowly progressive jaundice due to obstruction by fibrosing pancreatitis has been reported. The glycosuria of diabetes when present appears late in the disease following extensive destruction of the gland. X-ray evidence of pancreatic lithiasis or diffuse calcification is responsible for accurate diagnosis in an increasing number of cases as it was in the case reported here.

Pancreatic lithiasis appears to follow and accompany pancreatitis and the same factors play a part in its pathogenesis. Calcium carbonate and tribasic calcium phosphate are the chief constituents of these stones. Pancreatic secretion is said to contain very little of these salts. It is thought that inflammation and infection alter the chemical composition of the pancreatic juice in some way permitting the deposition of these salts. It is also believed, that in areas of acute fat necrosis fatty acids split from neutral fat by lipase combine with calcium to form soaps. This is probably the mechanism involved in diffuse pancreatic calcification. Large amounts of calcium are mobilized in the pancreas in areas of fat necrosis.[15]

Diagnosis is aided and confirmed by certain laboratory procedures the most important of which is the study of the duodenal secretions for quantitative determination of the pancreatic enzymes; amylase, lipase, and trypsin. In chronic pancreatitis these may be absent or greatly reduced in amount. Gross, microscopic and quantitative evidence of increased fat and protein in the stool is present if the patient is suffering from this disease. Diminished or absent pancreatic enzymes in the stool support the diagnosis. Quantitative determinations of serum amylase are not of assistance in chronic pancreatitis unless the patient is having an acute exacerbation of the disease with increase in serum amylase. After the subcutaneous injection of a pancreatic stimulant such as mecholyl a rise in serum enzymes is expected. In a patient with a severely fibrosed pancreas this anticipated rise may not occur.

Treatment of chronic pancreatitis is often difficult. Diabetes mellitus, if present, should be treated with diet and insulin in the usual way. In patients with steatorrhea, however, diabetes is frequently difficult to control because of the necessary reduction of the fat intake and because of the wide fluctuations observed from day to day in the insulin requirements of these patients due to variability in small bowel absorption and motility. There has been no problem in the patient presented because of the relatively mild diabetes he shows and his prompt response to fat restriction. To those patients who do not respond well with a decrease in fat consumption pancreatic ferments should be given. Fresh raw pancreas has been prescribed on occasion.[16] Bargen and his associates administered pancreatic juice obtained from dogs and treated with trichloracetic acid to 2 patients with relief of steatorrhea and gain in weight.[17] A potent commercial enteric-coated pancreatic preparation, given in large doses, is the only substance of this type that can be readily obtained and prescribed by the average practicing physician. Dosage up to 25 grams daily has been administered with benefit.

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Figure 1.—A-P and lateral views of the abdomen demonstrating diffuse calcification throughout the entire pancreas.

Hemorrhage Into An Adenoma Of The Thyroid

A CASE REPORT

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It is well known that hemorrhage into adenomas of the thyroid is quite common. One pathologist[1] has said that it is seen in practically every one. However, enough hemorrhage to require immediate surgical intervention is very rare.

Elsgerg,[2] in 1910, reported a case of hemorrhage into a thyroid cyst that recovered following emergency surgery. Von Burg[3] reported 12 cases of hemorrhage seen at the Zarick Surgical Clinic over a period of twenty years, but none were severe enough to warrant surgery. Von Ziemacki[4] reported the case of a 65 year old woman who had a hemorrhage into the thyroid gland that broke through the fascial planes of the neck and dissected down to the umbilicua. The patient recovered without surgery. Plummer[5] pointed out that hemorrhage into the thyroid gland even in small amounts, frequently caused pain in this region.

McGregor and Cornett[6] reported the case of a 68 year old woman who had several attacks of minor hemorrhage into the thyroid gland. Then followed a massive hemorrhage and the patient expired during surgery.

In 1931, Clute[7] reported on the common occurence of hemorrhage into adenomas of the thyroid. He stated in his report that up to that time no patients had been seen at the Lahey Clinic where a hemorrhage into the thyroid was severe enough to endanger life.

We think the following case is worthy of inclusion in the literature because of the infrequent occurence of acute hemorrhage into the thyroid gland. Also because of the necessity of prompt diagnosis and treatment of this surgical emergency.

A 35 year old woman was seen in the Medical Clinic of Jefferson Davis Hospital on Feb. 11, 1947. At this time the patient complained of a swelling in the neck which had been present for three years. She was well nourished and appeared to be in good physical condition. Physical examination was completely negative except for a diffusely enlarged, freely movable, soft, thyroid gland with no signs or symptoms of hyperthyroidism. A diagnosis of multiple colloid adenomatous goiter was made and the patient referred for a basal metabolism test, which showed a rate of 3.5 on February 19, 1947. The patient was given Lugol's solution, ten drops three times daily, and advised to return in one month.

On March 27, 1947, the patient came in to the hospital emergency room complaining of chills, fever, and aching all over. She stated that she had begun to feel badly twenty-four hours before. Physical examination at this time revealed an anxiously ill patient with dyspnea and fever. Her body was hot and moist, the head was negative. The thyroid was enlarged. The chest showed equal expansion and normal fremitus but there was slight dullness with rales in the base of the right lung. The abdomen, pelvis, rectum, and extremities were negative. Reflexes were physiological. Blood pressure 130/80.

Laboratory findings; W.B.C. 11,500 with polys. 86%; lymphs 12%; monos. 2%. R.B.C. 4,150,000 with 84.4% hgb. Urine negative.

Roentgenographic examination of the chest showed an area of pneumonitis or atelectasis in the lower right lobe of the lung. A diagnosis of pneumonia was made and treatment with chemotherapy was instituted along with parenteral fluids, sedation, and oxygen.

Four hours after admission to the hospital the patient became more dyspneic and was struggling for air. She was then seen by the otoparyngologist who advised bronchoscopy. This was done but with no relief of dyspnea. The bronchoscope was inserted with difficulty due to a collapse of the trachea. No foreign bodies were discovered but there was a quantity of thick yellow mucous and the mucosa of the trachea was acutely inflamed. In view of the complete collapse of the trachea it was thought best not to do a tracheotomy. With the aspiration of the mucous and the institution of straight oxygen, the patient seemed to improve for a short time.

A few hours after bronchoscopy, the patient appeared to be almost in extremis. At this time it was noted that the thyroid gland was larger and more firm than formerly. A diagnosis of hemorrhage into a thyroid adenoma was made and it was decided to take the patient to surgery.

At the time of operation, twelve hours after admission, the patient was moribund and no anesthetic was necessary. On opening the neck, a large adenoma was seen and removed. The condition of the patient continued critical and in view of the long compression of the trachea, a tracheotomy was done. The lobes of the thyroid appeared to be normal and were not disturbed. The adenoma had arisen from the isthmus of the thyroid, was partially sub-sternal, and somewhat pedunculated.

The immediate post-operative condition of the patient was poor and the cyanosis and dyspnea continued in spite of a large tracheotomy tube and the

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administration of oxygen. After forty eight hours the patient improved rapidly and was able to be out of bed on the third post-operative day. Recovery was uneventful and the patient was discharged on the sixteenth day after surgery. Subsequent follow up showed the patient to be entirely well.

Pathological section of the tissue removed at surgery revealed a thyroid adenoma with hemorrhage into it.

Summary:

Hemorrhage into the thyroid gland severe enough to require immediate surgery is seldom seen.

Acute hemorrhage into the thyroid gland does endanger life because of pressure on the trachea. This pressure must be relieved either by tracheotomy or surgery of the gland itself.

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New Research Discoveries*

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I am deeply appreciative of the honor you have done me by asking me to say a few words to you on this occasion. During the past year or so, a number of medical organizations, including the American Medical Association, have celebrated their centennials. On such occasions, it is customary to look back and review the progress which has been made in the century just past. This, however, is not a very fruitful occupation unless one uses the information so obtained to predict the probable future course of events and to adapt one's course to direct such future actions into the most profitable channels.

In discussing a subject such as "New Research Discoveries," one cannot expect to do more than touch on some of the more significant advances, and, to make such a subject intelligible, some attention should be paid to the methods employed by scientists in discovering new facts and in developing new theories. Such a discussion reveals that the scientist, as an individual, like scientists collectively, commences a new project by first looking backward. However, he would never make a new discovery if he contented himself with merely a survey of progress made in the past century. I can make this statement positively because medicine went through a period wherein its leaders contented themselves with a contemplation of the past and did not bother to apply the lessons so learned to the making of new discoveries. From the time of Galen until the Renaissance, no real progress was made in medicine. The writings of Greek, Roman, and Arabic physicians were accepted as gospel, and medical research was unknown. Then, a few original thinkers appeared, and contributions of a substantial nature began to be made. As more and more men became imbued with the spirit of scientific inquiry, the discoveries multiplied in geometrical proportions. During the past century, the period over which your own State Medical Association has existed, tremendous strides have been made in scientific medicine. In fact, so great has been the progress in the past 100 years that enormous volumes are necessary to record the significant facts which have been established by medical research.

Today, I would like to mention a few of the more recent discoveries which I believe will be of significance in the practice of medicine. In doing this, I am taking the chance of all prophets, that I shall be proved wrong. I trust, however, that my prognostications will be somewhat more accurate than those of certain well-known radio commentators.

All of you are familiar with the fact that the

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products of atomic disintegration have opened new vistas to the medical scientist. One of the most practical and important peacetime uses of the knowledge gained through the development of the atomic bomb is the production of radioactive elements for use in medicine. It should be remembered that long before the development of atomic science as we know it today, radioactive substances have been used in the diagnosis and treatment of disease. Radium and some of its disintegration products, chiefly radon, have been used in medicine for more than thirty years. With the development of the cyclotron, small quantities of artificially radioactive elements became available to medical scientists. Two of these, radioactive iodine and radioactive phosphorus, were used to treat disease before the war. The atomic pile has now made available substantial quantities of many of the radioactive elements formerly produced in minute quantities by the cyclotron and, in addition, has produced a large number of new radioactive elements.

There are two principal uses for these radioactive elements, or isotopes, as they are usually called. Because these elements give off particles in the form of rays, extremely small quantities can be detected and measured by special instruments. The emission of these rays by radioactive isotopes permits one to photograph the location of the element. Furthermore, one can introduce into the body a chemical or drug containing one or more of these isotopes, and because the drug is "tagged" or "labeled" by this radioactive element, its course in the body can be followed, and any changes to which the drug or chemical is subjected can be determined, whereas ordinary chemical methods might not differentiate between the drug and other body chemicals. Such investigations with radioactive isotopes are called "tracer" studies, and through them we are learning many fundamental facts regarding bodily processes, drug action, and the effects of disease on the body chemistry. The radioactive isotopes have become additional tools in the hands of the medical investigator.

Like all tools, they must be used properly and intelligently, and they have very definite limitations. Not all problems can be solved by the use of radioactive elements, and incalculable harm may be done by misapplication or unskilled use of these tools. The Atomic Energy Commission is taking extraordinary precautions to see that only qualified experts obtain these tools. This is necessary for their own protection as well as for the protection of the public, since radioactivity in any form is dangerous.

The second use for radioactive isotypes in medicine is the treatment of disease. Since these elements give off radiations similar to x-rays and radium, the effects produced on the body cells are almost identical with those produced by these well-known therapeutic agents. However, by the proper selection of elements, selective irradiation of specific tissues can be achieved. When cancer, for instance, is treated with x-rays, it is seldom possible to apply these rays just to the cancerous tissue. Inevitably, normal tissue lies in the path of the x-rays, and damage to normal bodily structures can occur. However, if the substance giving off these rays can be concentrated in the organ affected by the cancer, the harmful effects on normal tissue will be greatly minimized.

Radioactive iodine has been used to treat certain types of goiter. The thyroid gland picks up circulating iodine and concentrates it. Therefore, if some of the iodine taken into the body is made radioactive, it will quickly be picked up by the thyroid gland, and most of the rays given off by the radioactive iodine will affect only the goiter.

Leukemia, a disease of the white blood cells, which can be considered a "cancer" of these cells has been treated with radioactive phosphorus which circulates in the blood and may be deposited in bone, one of the sites of formation of white blood cells. Unfortunately, radioactive phosphorus is not a cure for leukemia, but some patients are made more comfortable and their life may be prolonged by this treatment.

Similarly, radioactive phosphorus has been used successfully in the treatment of polycythemia vera, a disease in which there is an excessive production of red blood cells. These cells and the cells from which they are formed in the bone marrow, appear to be particularly sensitive to the radiations given off by radioactive phosphorus.

Other elements such as gold, sodium, and iron have been made in the radioactive state, and their therapeutic properties are being explored. We shall undoubtedly hear more of these in the near future. A word of caution, however; one should not expect miracles from the applications of atomic energy to medicine. The effects and limitations of the radiations produced by these products have been known long before the development of the atomic bomb. The ultimate effects produced by these elements can differ little from those produced by x-rays or radium. They do, however, provide a new method of applying the radiations and, thus, can be considered a refinement of already well-known treatment methods. Do not be misled by over enthusiastic newspaper reporting regarding the possibilities of these substances in medicine.

Now, let us turn to some other medical problems, less exciting perhaps, but nonetheless significant. Not so long ago, the southern part of the United States, including your own beautiful state of South Carolina, had a fairly serious malaria problem. Perhaps some of you have been victims of the ubiquitous plasmodium and have had to take quinine at one time or another. All of you, I am sure, know how unpleasant and even dangerous a severe attack of malaria can be. Thanks to the efforts of your Public Health Officials and to your Sanitary Engineers, malaria is no

longer common in this country, and in fact, it is almost totally wiped out as an endemic disease in the South.

This state of affairs is, unfortunately, not true for vast areas of the world. Malaria was one of the factors responsible for the defeat of the Japanese land forces in the South Pacific. On the other hand, the development of effective antimalarial agents by scientists in this country was one of the major contributions to victory of our forces.

Before the war, there was available two antimalarial drugs: quinine and atabrine. Both are effective in suppressing certain forms of malaria, but neither can be relied on to cure the disease. Furthermore, quinine supplies were cut off by the Japanese invasion of Southeast Asia, and atabrine was not thought to be a satisfactory substitute. I might remark that we now know that it is. Both drugs produce some unpleasant side effects; quinine can make you deaf, and atabrine can turn you yellow. Personally, I'd rather be yellow than deaf, but some of the soldiers and medical officers, early in the war, felt differently.

The Office of Scientific Research and Development instituted a gigantic testing program to find new and effective synthetic antimalarials. In four years, over 16,000 chemical compounds were tested in animals for their ability to prevent or cure malaria and for their possible toxic effects. Out of these 16,000 chemicals, three new ones having superiority to quinine and atabrine were found. Two of these, chloroquine and chloroquanide, are now available and another, pentaquine, may be made available; unfortunately, however, it is fairly toxic although extremely effective against some forms of malaria.

All of you are familiar with the development of penicillin and streptomycin, and I do not think I need discuss these today. However, you may be interested in the work going on leading to the development of new antibiotic drugs to treat infections which do not respond to penicillin or streptomycin.

Since the discovery of penicillin, more than fifty antibiotic agents produced by molds, fungi, bacteria, and even plants, have been studied. Many of these have been discarded because they offered no advantages over penicillin or streptomycin, or because they were toxic when given to animals in therapeutic amounts. At present, there are three antibiotics under intensive study which appear to have some promise.

Bacitracin, a substance produced by a bacteria originally isolated from a bone infection of a little girl named Margaret Tracy, and named in her honor, seems to attack the same organisms as are attacked by penicillin. It may be useful in those instances where an individual is allergic to penicillin. It appears to be relatively nontoxic and is now undergoing extensive clinical trial. Several pharmaceutical manufacturers are developing methods of producing bacitracin on a large scale.

Chloromycetin, a substance derived from a soil fungus, has shown possibilities of being effective against the organisms causing typhus and Rocky Mountain spotted fever, and against some virus diseases such as psitticosis and encephalitis. Only experiments on infected eggs and a few mice have been reported, and much more work will have to be done before we can be certain that chloromycetin will be a new "miracle drug." Its importance lies in the fact that, heretofore, virus diseases have not responded to any antibiotic or other chemotherapeutic agent. Perhaps, we are on the threshold of discoveries which will enable us to treat effectively such diseases as infantile paralysis, encephalitis, rabies, and other virus infections. I predict that in a few years we shall have effective drugs for these diseases; whether one of those drugs will be chloromycetin it is too early to say.

Very recently, another antibiotic substance derived from a bacteria which grows in the soil has been studied. This antibiotic was discovered almost simultaneously in this country and in England. In England, it has been called "aerosporin" and in this country "polymyxin." This antibiotic appears to be effective against a number of the organisms attacked by streptomycin and, in addition, may be effective against some that neither penicillin nor sereptomycin affect, such as the organism causing undulant fever.

Polymyxin has been tried in the treatment of undulant fever. Preliminary reports are encouraging, but because the disease is notorious for its chronicity, final evaluation of polymyxin therapy cannot be made at this time.

I have only mentioned three antibiotics which are currently receiving attention by medical investigators. These three seem to be the most promising of the many which have been discovered. However, there are literally thousands of microorganisms, many of which are capable of producing substances lethal to other bacteria. It seems possible that we shall continue to hear of new antibiotics with exciting properties, but it must be remembered that not every agent which kills bacteria in the test tube will do it in the body. Furthermore, the drug must be safe as well as effective. Determination of safety and effectiveness of any new agent is difficult and time-consuming, and hence, early optimistic reports may not be confirmed by later investigations.

In the time remaining at my disposal, I should like to tell you a little regarding some investigations on the treatment of cancer now proceeding under the auspices of the Therapeutic Trials Committee of the American Medical Association. This investigation is concerned with the relationship of hormones to cancer.

I shall not attempt to bore you with an array of technical facts but shall attempt to outline to you, in general terms, some of the curious observations which

have been made and tell you of the method which the Therapeutic Trials Committee has adopted to obtain fundamental information on this subject. Although I shall deal only with one isolated problem in cancer research, it should serve as an example of the manner in which research is conducted and the principles which must be observed in advancing the frontiers of medical knowledge.

I believe that you all are familiar with what we mean by "hormones." However, I might refresh your memory by stating that these substances are chemicals formed in certain glands of the body, secreted into the blood stream and which produce their effects on a variety of tissues and organs. For instance, the islet cells of the pancreas secrete insulin which regulates the utilization of sugar in the body, the thyroid gland secretes thyroxine which regulates the speed with which we burn nutrients in the body to obtain energy—it is the so-called regulator of metabolism. Many of the characteristics which differentiate the male and female, both anatomically and emotionally, are determined and regulated by hormones secreted by the pituitary and gonads. All hormones bring about their characteristic effects because of certain specific actions on particular cells within the body. It is not surprising, therefore, that some of these hormones have been found to exert a profound influence on the growth of certain types of cancer cells, for these, after all, are body cells which have "gone wild" and are no longer held in bounds by the normal processes which restrain and direct cell growth.

Those hormones which have been found to have an action on certain types of tumor cells are those commonly called the "sex hormones" because they are secreted by the ovaries or testes, and because they are responsible for initiating and maintaining certain sex characteristics. The discovery that the sex hormones can alter the growth of cancer cells was made only ten years ago, although such an action was postulated nearly twenty-five years ago. The isolation and purification of hormones is a relatively recent accomplishment, and until the research worker had pure materials in adequate quantities with which to work, he could not pursue critical investigations on their actions.

In 1941, Dr. Huggins of the University of Chicago, showed that carcinoma of the prostate gland could be checked, and in some instances, be made to disappear for varying periods of time by removing the testes. It was apparent from his observations that in the absence of the male sex hormone, the cancer cells derived from the prostate gland could not grow, and, in fact, often could not maintain themselves. In other words, the male sex hormone was one factor responsible for the growth of these cancerous cells. We know that it is not the only factor, and probably, the male sex hormone has nothing to do with *causing* the cancer. It does, however, provide a proper stimulus or environment for the growth and multiplication of these cells once they are present.

These observations of Huggins on the effects of castration on prostatic cancer, suggested to him another approach to the treatment of such tumors. When a young man is castrated or fails to develop functioning testes, he assumes many of the characteristics of the female. What, then, would happen if large doses of the female sex hormone were administered to men with prostatic cancer? This was tried, and, as you have probably guessed, the cancers stopped growing and often disappeared temporarily. The results were not always as dramatic as those seen after castration, but for the first time, a chemical substance had been shown to exert a beneficial action in cancer.

It was reasoned that if the female sex hormone, or estrogenic hormone, as it is known, could inhibit cancer in the male, perhaps the male hormone could inhibit cancer in the female. It was known that removal of the ovaries sometimes produced temporary beneficial effects in women with breast cancer. It was also known that administration of the male hormone to women often produced effects quite similar to those seen after castration. Therefore, testosterone, the male hormone, was tried in the treatment of breast cancer. The first trials were very disappointing, but two years ago, Dr. Frank E. Adair of New York, reported eleven cases of far advanced breast cancer whose disease had attacked the bones, which responded with dramatic pain relief and disappearance of some of the cancer tissue in the bones. Dr. Adair's success appeared to be due to the use of doses of testosterone about ten times greater than those of his predecessors.

Now, as a result of these observations, a theory regarding the effects of hormones in cancer was advanced; briefly stated, this theory was that the normal sex hormones provided a stimulus to the growth and maintenance of cancer cells originating in those body organs normally controlled by the sex glands. Administration of a sex hormone, not normally present, created an unfavorable environment for these cancer cells, they ceased to grow, and many of them died. This was a very nice theory until some English workers and a group at Massachusetts General Hospital, under the leadership of Dr. Ira T. Nathanson, knocked it into a cocked hat by showing that, in some instances, the *female* sex hormone would inhibit breast cancer in the female!

It was obvious that a much deeper search would have to be made into the relationship of hormones and cancer if an explanation of the observed facts was to be found. Furthermore, not all patients respond to hormone therapy, and in some, it seems to make the disease spread faster.

Great interest in this field of therapy had been aroused, and the manufacturers of these hormones were besieged with requests for donations of material

to treat indigent cases. Finally, several of these manufacturers approached the Therapeutic Trials Committee with the request that a thorough investigation of the usefulness of these hormones in breast cancer be undertaken with a view to determining, if possible, how and why these effects are brought about.

To cut a long story short, the Committee agreed to institute such an investigation and appointed a subcommittee to plan and evaluate this work. Fourteen pharmaceutical manufacturers have agreed to furnish the needed hormones free of charge; the amount of material being donated is valued at nearly $100,000.

Many competent men were already at work on various phases of this problem, and others were interested. The subcommittee has enlisted the aid of forty-nine institutions in thirty-eight cities in this country and Canada in collaborating in this project. The subcommittee has established a basic pattern for the investigation, but each collaborating group is pursuing a study of a particular phase of the project in which he has an interest and for which he has facilities. Through the cooperation of the Army Institute of Pathology in Washington, the records and specimens obtained in this study will become a permanent collection, available to all medical investigators who may wish to see the original data obtained by the participants in this project.

All of these investigations are being made with the cooperation of patients with advanced cancer of the breast. It is expected that by the end of this year, nearly 1000 persons will be under treatment with hormones, and the information gained by a careful study of these unfortunate individuals may eventually point the way to their salvation and to the salvation of others similarly afflicted.

The active institution and participation by the American Medical Association in major research projects is a relatively new venture. Heretofore, the Association has made grants of money to medical investigators and given encouragement to others. Now, however, the Association, through the Therapeutic Trials Committee, is actively initiating research projects, not only in cancer, but in many other fields.

I would like to tell you more about the various research activities of the American Medical Association, but time does not permit. I think, however, that the very brief sketch I have given you will indicate that, as it has during the past 101 years, the Association is ever seeking ways to bring better health and higher standards of medical care to the American people.

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Nov. 2, 3, 4.

The Journal of the South Carolina Medical Association

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OCTOBER, 1948

AN ORCHID

As members of our Association attain honors it is only appropriate that they be given full recognition.

In an advance copy of the program for the Section on Proctology, Southern Medical Association, we find the name of our former past-president, Dr. Thomas Brockman of Greenville, listed as chairman. The subject of his address will be "How May A Proctologist Best Serve His Patient and The Profession."

Congratulations, Dr. Brockman, and may many members of our Association be in the audience when you deliver your speech.

JOHN H. PORTER

When Dr. John H. Porter died recently, the medical profession of South Carolina lost one of her strongest supporters, and the Medical College one of her most loyal friends.

A general practitioner in Andrews, Dr. Porter soon became interested in political affairs. For a number of years he served as a Representative from his county in the General Assembly, and for the past few years was Chairman of the Committee on Medical Affairs of the House. Legislation dealing with the medical affairs of the state was sent to his committee where he saw to it that careful study was made and strenuous effort was exerted to see that it was in line with the best thought of our Association. Dr. Porter was also, for many years, a member of the Board of Trustees of the Medical College and gave freely of his time and talents toward the promotion of its interests. At the time of his passing, Dr. Porter was the only member of the House of Representatives who was a physician.

His friends and colleagues mourn his passing and extend their deepest sympathies to his family.

PIEDMONT POSTGRADUATE ASSEMBLY

The annual Piedmont Postgraduate Assembly, held recently in Anderson, was a great success. With good speakers, a good variety of subjects for discussion, and over 135 in attendance, it proved to be even better than former gatherings. And far from the least important part of the meeting was the gracious hospitality of the physicians of Anderson.

The physicians of the Piedmont section of this state are due a great deal of credit for the time and effort which they have expended in making this annual affair so notable. Other sections of the state would do well to heed the example set by our colleagues in our northwestern counties and to promote similar institutes for their members.

THE EWING REPORT

Oscar Ewing, Federal Security Administrator, has presented his report to the President who in turn released it to the nation. It is to be regretted that Mr. Ewing did not confine his recommendations to those which were adopted at the National Health Assembly. Instead, he included such recommendations as met with his approval, and then added his personal recommendations. One of the latter was the advocacy of a federal health insurance plan for all the people. So far as we can see, there is only one reason for Mr. Ewing's premature presentation of his report. This is a political year and Mr. Truman wanted the report as ammunition in his campaign.

To those who have followed Mr. Ewing's speeches and actions, there is nothing new or startling in the report. It is a well prepared and readable document presenting the arguments of those who are in favor of a system of federal medical care for the people of this country. Every physician would do well to secure a copy of this report and to read it carefully if he is to participate intelligently in the debate which lies ahead.

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE DIRECTOR AND COUNSEL

BRITISH HEALTH SERVICE APPRAISED

Britain's new Health Service, according to the story appearing in a recent issue of the London Daily Mail, "is menaced by the humbug."

Shades of Scrooge and Marley's Shade! The "humbug" used in the newspaper, however, seems to have a more specific meaning than the favorite expletive of the central character in Dickens' novel. The "Humbug," says the Daily Mail, "is the man or woman who needlessly wastes the overworked doctor's time and steals his care and ministrations away from the sick and suffering."

According to the writer, Britain's 18,575 National Health Service doctors are dreading the winter after a July and August during which there has been more "sickness" than in any summer within memory. The writer continues, "It has already become obvious that the scheme's popularity is its worst enemy. The enthusiasm with which the public has received it now threatens to throw it into chaos.

"During the past week I have invited doctors—some who were originally "for" and some who were "against" the service—to give their judgment on it based on eight weeks' experience.

"And nearly all are agreed on this one main trouble—too many patients.

"Take for example, a young Essex doctor who has built up a successful private practice as a general practitioner.

"He owns a small house and in it has a well-equipped surgery with a waiting-room designed to accommodate 17 patients.

"At his morning session, which is supposed to last two hours, he now often has over 60 patients. Once he found 73 people waiting for attention.

"In a day he frequently deals with a total of about 120 callers at morning and evening surgeries—and has to find time in between to call on 25 or 30 patients who are too ill, or say they are too ill, to leave home.

"Another doctor with an even smaller waiting-room sometimes has a queue through his home and garden and out into the street."

Despite the new role as servants of the State, the physicians in England have not lost their professional interest. The writer in the Daily Mail reports that "The doctors' worry is not so much overwork. They are afraid that they are being rushed out of giving the careful attention which many of the cases deserve.

"Of the extra patients who are now flocking to the surgeries many are genuine enough. They have ailments which have long been neglected probably for financial reasons.

"But there are others with imaginary or trifling complaints who previously have been deterred from visiting a doctor by the knowledge that it would cost them a few shillings.

"Worst menace of all are those with imaginary ailments who phone to the doctor demanding that he pay an immediate visit.

"Although the doctor may be almost convinced that a visit is unnecessary, he usually dares not risk refusing to go.

"One doctor showed me his visiting book for August, 1947, and August, 1948.

"The book for this August revealed, apart from a 100 per cent increase in visits, a far bigger percentage of cases crossed off after the first call."

The article continues, pointing out that in addition to the shortage of doctors developed by the great influx of patients, the demand for medicines has soared, with chemists reporting increase of between 75 and 100 per cent in prescriptions dispensed, resulting in a serious shortage of small bottles. There has been an increased demand for free spectacles and hearing aids. According to this writer, there is a belief on the part of some that there is a change in the old doctor-patient relationship. Now they say they are all too often regarded as civil servants merely doling out a ration.

The writer, so far as his by-line indicates, is not a physician. He is a newspaper reporter or feature writer. It may reasonably be assumed that he reported the facts as he found them, impartially and without conscious prejudice.

SUPPORT OF AUXILIARY BY STATE SOCIETIES URGED

The following Resolution, proposed by a Delegate from the Oregon State Medical Society, was adopted by the House of Delegates of the American Medical Association at its recent annual meeting in Chicago.

In thus endorsing the principle of direct, active financial support of the Women's organization by constituent State Medical Societies, by appropriation of funds to defray their expenses, the national body followed, whether knowingly or not, a step which had already been taken by the South Carolina Medical Association. At the May meeting in Charleston, Council approved the payment of travel and other expenses of the President and certain other officials of the Woman's Auxiliary.

In other ways South Carolina has been in the vanguard of the thinking on the practical importance of the Woman's Auxiliary. It is hoped that all the state organizations will follow the suggestion contained in this Resolution.

The inactivity following surgery or disease, and often encountered in the aged, makes constipation a likely occurrence. Dehydration, too, frequently is a significant contributing factor.

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RESEARCH IN THE SERVICE OF MEDICINE

SEARLE

"Whereas, Our local state and national woman's auxiliaries have become an indispensable adjunct of organized medicine; and

"Whereas, The local state and national auxiliaries are especially effective as agencies for furthering the education of the public concerning the aims and accomplishments of scientific medicine; and

"Whereas, Their maximum effectiveness requires participation by the wife of every member and sufficient funds to enable them to carry on their essential activities; therefore be it

"RESOLVED, That each constituent state medical association be urged to budget sufficient funds to defray the cost of the activities of its auxiliary and to pay the annual dues of the national auxiliary, thus making the wife of every member automatically a member of the state and national auxiliaries and eliminating the collection of state and national auxiliary dues from individual auxiliary members."

MRS. ADCOCK APPOINTED REGIONAL CHAIRMAN

Mrs. David F. Adcock of Columbia has been appointed Regional Chairman and a member of the Standing Committee on Legislation of the Woman's Auxiliary to the American Medical Association. The southern region which Mrs. Adcock will head in this important phase of the work of the national body consists of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee and Texas.

The outstanding work led by Mrs. Adcock as President of the Woman's Auxiliary to the South Carolina Medical Association last year, was an achievement which will be remembered with pride by members of the Auxiliary and the Association alike. As Regional Chairman on Legislation for the national organization, her duties will be to keep posted and stimulate interest on legislative matters and to coordinate legislative activities among the states in her region.

THE DOCTOR AND PUBLIC HEALTH*

*The address of Leo F. Simpson, M. D., President of the Medical Society of the State of New York, Delivered before the Annual Conference of Health Officers and Nurses, Saratoga Springs, N. Y., July 21, 1948.

It was, I believe, H. G. Wells, the late English writer and historian, who made the pertinent remark that education is a race against catastrophe. It seems to me especially significant that we are gathered here at this time to evaluate our experience in the field of health and medicine while at the same time it would seem that the world is tottering on the brink of a terrible abyss opened up by the advent of the atomic age.

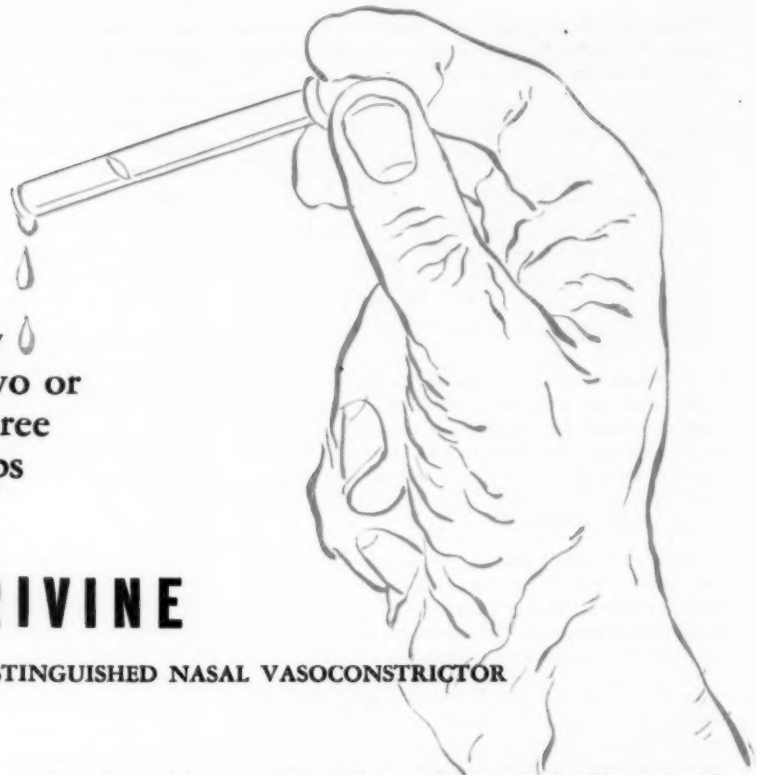
It would perhaps be more accurate to state that the threat of disaster comes not from the enormous strides taken by science, for these steps could lead to a peaceful world—a world in which man could realize his potentialities more than ever before. No, the fault is in the failure of the human mind to evolve proper methods of dealing with the new tools which scientific research has made available.

In a sense, we who devote ourselves to the health and welfare of mankind, individually as well as collectively, stand as a thin line of shock troops against the destructive forces which are threatening to nullify all the advances of science which have enabled man to rise above the savagery of his primordial days to the comparatively advanced civilization in which we live today. But we are a *thin* line. The strength of the opposing forces, now still but a threat, is so enormous that, should it materialize, the accumulated work of centuries of progress will be obliterated in a moment. Within the experience of most of us, two violent wars have occurred and each of these has had its retrogressive effect upon our general well-being. It must be plain to anyone who thinks about the situation that the general level of health cannot but suffer a decline, when the very flower of our race is periodically sacrificed to the gods of war.

Thus, it appears to me that we are in a position now where not only must we work to our utmost, to rectify the blunders of the past, but we must strive in every way to keep the frail plant of human existence from becoming uprooted by the gathering storm.

Much has been said and written of the divergence between the aims of the individual doctor and the advocates of public health, but I am not one who believes that they stand in opposition to each other. I look upon the physician and the public health officer as mutually supporting each other in their efforts to enable man to live more successfully in his environment. That one may be said to concern himself more with the environment, and the other with the individual, does not alter the close relationship of the two. Even this is not an accurate statement of their mutual dependence because of the frequent overlapping of the two fields. That there should be opposition between the two is a mistake. Disagreements that have arisen in the past have been largely due to the failure of either one or the other to realize that they have a common objective. In peace time we should be as brothers in our efforts. In time of war we march shoulder to shoulder.

The doctor, without doubt, is an individualist; the public health officer thinks in terms of entire populations. But we must not lose sight of the fact that the doctor is equally concerned with the welfare and well-being of the community at large. Whether the viewpoint be that from above or below, the aim cannot be different. It is perhaps difficult for those who have been trained to accept the larger view, to understand the doctor's emphasis on his personal relationship with his patient. It is this relationship which the



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doctor traditionally guards and which has made him hostile to schemes for providing medical care which would break down this relationship.

No one recognized more than the doctor the right of anyone, regardless of race, creed, color or economic circumstance, to good health. No one is more aware than he of the need for a wider and better distribution of medical care. But he does insist that medicine is a profession and that in the personal administration of his professional skill, in the treatment of the individual *as* an individual, with regard to all the special circumstances which his individual case arouses, the sanctity of this personal relationship must be maintained.

It is discouraging to the doctor to see himself pictured as an obstacle to progress, because of his insistence upon the maintenance of the high quality of medical care. No matter how imperative may be the expansion of the quantity of medical care, we can gain nothing in our effort to increase its availability if the quality is reduced.

We in the United States pride ourselves on having the highest standards of medical care and public health in the world. Let us guard against a deterioration brought about by excessive eagerness to meet a problem that has no simple solution.

At the recent National Health Assembly in Washington, there was general agreement that the principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services and avoid the indignities of a "means test." This principle was approved by all the participants at the conference—even by those who are known to entertain divergent views. As a principle, it stands as a laudable statement. I suspect, however, that it will be subject to various interpretations by persons of different views and that the term "contributory health insurance" will require a clearer definition before the principle can be translated into action.

If the future shows that "contributory" health insurance is meant to mean "compulsory" sickness insurance, with its regimentation of the physician and the removal of the right of the patient to the free choice of his own physician, you can expect the medical profession to throw its weight against it. If, on the other hand, there is a sincere attempt to set up a program of insurance which will enable the patient to provide for the costs of medical care in a democratic way, you will find that the medical profession will not only support it, but will lend its earnest cooperation to widen the benefits of such insurance even well beyond its present limits.

It is well known that doctors have shown their willingness to cooperate in voluntary group health pre-payment plans providing comprehensive service to their members. In recent years this cooperation has found a surprising amount of acceptance on the part of the public. Here in New York State, where there are six pre-payment plans that have met the approval of the Medical Society of the State of New York, membership in these plans has risen phenomenally within the last few years and now stands at 1,300,000 persons.

I mentioned earlier that the doctor occupies himself with the problems of the individual while the public health officer is concerned with community environment. I tried to emphasize that the cleavage between the two is not, and should not be, sharp. Naturally the doctor cannot regard his patient entirely as an isolated phenomenon; neither can the public health officer deal entirely with abstract statistics and concern himself with communicable diseases, sanitation and hygiene without regard to the individual. Nevertheless, the best interests of the patient as an individual, and as a member of his community, will be best served by a steadfast devotion by all of us to those phases of health and medicine in which we are each best trained to function.

The very first section of the Principles of Ethics of the American Medical Association, it should be remembered, states:

> "A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals."

Those who are familiar with the Ten Point Health Program of the American Medical Association are well aware that it embodies provisions that are carefully planned to bring to the American public the maximum benefits of modern medicine at a cost they can afford to pay, and that it also provides for a full complement of public health services rendered by professionally competent health departments.

The pattern has thus been set for a wide area of joint effort on the part of the medical profession and the public health officials. There remains, of course, much to be done in singling out problems and combining the resources of both to overcome them. Undoubtedly there will still be room for considerable differences of opinion and a healthy scepticism on both sides. But the end result will be a closer approach to the fundamental solutions of the problems that beset our society's constant search for a higher standard of health.

There is one particular area for cooperation of which I might make special mention, and this is one which will engulf us if the threat of atomic warfare to which I referred in my opening remarks becomes a reality. All of us, I am sure, have given serious thought to the staggering health and medical problems that will follow in the wake of an atomic ex-

plosion. We doctors, and I know many of you, too, have recently started to prepare for such an eventuality. We are fully aware of the vast amount of coordinated effort which must go into the preparation for meeting an emergency on the scale of that which is likely to present itself should atomic disaster strike. We are resolved to take our proper place in the battle for survival and give of our utmost to the common cause.

There are, however, several disturbing elements in the atomic defense picture, and they are matters that I believe should be given careful consideration.

It is generally recognized that the explosion of a single atomic bomb in a metropolis of a million or more people may cause 300,000 casualties, and that a large number of these—possibly 100,000—will suffer from shock, hemorrhage and the effects of radio activity. They will be in need of immediate blood transfusions. It also is accepted that the present facilities for collecting, storing and transporting blood are insufficient to meet the demands of an emergency of such proportions. None of the metropolitan areas could, by themselves, supply more than a fraction of the need for whole blood for their own use should they be ravaged by an atomic bomb, even supposing that their existing supply miraculously escaped destruction.

Once we have agreed that an emergency situation is a possibility, it follows as a matter of course that some way must be found to collect, store and distribute the vast quantities of fresh whole blood that will be required. Under those circumstances, there appears to be no other way than to enlist the cooperation of those voluntary organizations best able to undertake the task.

An extraordinary problem must be met by an extraordinary solution. No large-scale emergency can ever be coped with by business-as-usual methods. Hiroshima was no optical illusion.

Yet, I would not be faithful to my trust as President of the Medical Society of the State of New York if I were to be silent regarding some serious difficulties which are connected with plans for wholesale blood collection, no matter how well-intentioned.

First, it seems to me that the doctor has an inescapable moral and legal responsibility to the patient for the safety of the blood given to him, whether in times of peace or in war. This is a responsibility that he cannot shirk or transfer to others, and neither is it proper that others assume it. The doctor's whole concept of his role in society is open to question if he blindly surrenders his plain duty under the presure of circumstance. I do not doubt that new situations call for new remedies, but I do not believe that fundamental principles ever change.

Consequently, I must make myself clear that the medical profession always will be compelled to insist that the creation of large resevoirs of blood be undertaken under the strictest kind of medical supervision, and under conditions best suited to safeguard the health of everyone involved. This has been the principle that has too easily been waived by well-meaning persons, even in times of peace, in their eagerness to create blood banks as a community service. Here in New York State, the medical profession has been made to appear reactionary and self-interested, simply because it has sought to prevent a widespread deterioration of the supply of whole blood due to a decline in standards. This is unfair. There is, no doubt, strong popular pressure for the establishment of blood banks on a large scale, and it is fitting that, wherever proper methods for collection and distribution can be set up, such banks should be established. But the insistence upon adequate safeguards, and blind opposition to progress are two different things. A more ready willingness on the part of those who advocate community blood banks to understand the medical point of view, would do much to clear up misunderstanding.

The second point I wish to raise goes behind the surface and deals with the philosophy involved. The proposal to operate emergency blood banks in times of disaster can scarcely be questioned. No doctor would withhold from anyone in such a circumstance, any more than he would in a time of peace, every resource at his command and all his personal ability to save the life of any stricken person. But, the doctor, together with a great many others, cannot overlook the fact that the pattern of the past has too often demonstrated that under the guise of an "emergency", some of our most fundamental principles have been modified—ostensibly on a temporary basis—but, as we all know, they have remained firmly implanted long after the "emergency" has passed. The word "emergency" is elastic. In a sense, we are living under emergency conditions all the time and perhaps never more than now.

It seems to many of us that the tiny hole in the dike has already been widened to such an extent that we are near to being flooded by new un-American principles that first seeped in as temporary stop-gaps. Each further concession extends the breach and with each we move more and more away from the basic principles under which our nation was founded.

Good health can never be a controversial issue. We are not attempting to make it such. Yet we in the medical profession must express our concern over the apparent readiness of some persons to drift toward an economy of collectivism without heeding the manifold danger signs along the way.

I repeat. The presence of a national emergency will lead the doctor to modify his views on many things. But for several reasons he will do so reluctantly and, firmly convinced, that should the emergency happily fail to materialize, the normal pattern of operations should prevail.

Let me assure you that the medical profession will not be found wanting in time of need. We have a proud tradition behind us to serve as an example, and

we are ready to demonstrate that we aspire to be even more worthy of the trust placed in our hands. We believe that much can be accomplished by a united approach to the many problems that confront us, and we stand ready to contribute our best efforts toward the betterment of our fellow men.

It has not been my intention, by dwelling upon the possible horrors of an atomic disaster, to act the part of a Cassandra and paint the future with an unnecessarily dark brush. I have simply tried to be realistic in the face of unpredictable eventualities. It would be foolhardy to be excessively optimistic in the light of current events.

While the immediate future is far less bright than we would like, let us not give way to despair but rather look upon it as a challenge to bring out the best that we have to give to it. As an inspiration, I like to think of the words of Alfred North Whitehead, who, in summing up the position of science in the modern world, said:

"We must expect that the future will disclose dangers. It is the *business* of the future to be dangerous; and it is among the merits of science that it equips the future for its duties."

PUBLIC HEALTH NEWS

DOCTOR CHAPMAN EMPLOYED WITH MATERNAL AND CHILD HEALTH DIVISION, SOUTH CAROLINA STATE BOARD OF HEALTH

Doctor William H. Chapman of Bishopville, S. C., is now employed with the Division of Maternal and Child Health of the State Board of Health.

Doctor Chapman's work will be principally educational, with emphasis on the program of child growth and development and better family life. He will be available as a speaker to local medical groups; he will advise with the local health department staff in helping to bring about a better understanding and more consideration for the emotional side of the mother and baby in maternal and child health clinics; and he will participate in institutes for nurses (public health, institutional, and private duty), teachers, welfare workers, parent-teachers associations, and other groups who deal with child life.

Doctor Chapman has a background rich in both education and experience which will provide a wealth of knowledge for this work. He studied at Furman University, Greenville, S. C., and Mt. Vernon College, Baltimore, Maryland. He was graduated from the University of Maryland School of Medicine, and served his internship at Women's Hospital, Baltimore, Maryland, after which he was Resident at Petersburg Hospital, Petersburg, Virginia, for two years. For several years he was a Medical Officer with the Veterans' Administration Hospitals, his work there being chiefly in the field of psychiatry. In recent years Doctor Chapman served as assistant to Doctor Hugh Wyman, with the Richland-Columbia Venereal Clinic.

In June 1947, he completed a year of post graduate work in Psychiatry at the Child Guidance Home, Cincinnati, and the University of Cincinnati College of Medicine with Doctors Milton Rosenbaum and Krug Brady. Since that time he has engaged in private practice, limited to psychiatry.

DR. HEISE ACCEPTS POSITION WITH RED CROSS

Dr. E. Alex Heise, former director of the Sumter City-County Health Department, who recently resigned to become southeastern area medical director for the National Red Cross with headquarters in Atlanta, Ga.

Dr. Heise received his early education in the Columbia City schools and at Duke University. In 1933 he received his A. B. degree from the University of South Carolina. He graduated from the South Carolina Medical College in 1939. Following a year's internship at the Columbia Hospital he entered the University of N. C., and graduated in June, 1941 with the degree of Master of Public Health. He became director of the Sumter City-County Health Department on July 1, 1941.

TWO FALSE RUMORS

False rumors breed uncertainity and discontent. Definitely false is the rumor which has recently gotten out that syphilis is about to be treated now with 2 doses of penicillin, and that the Rapid Treatment Center, in Florence, S. C., is about to fold up.

There is nothing in the files of the Venereal Disease Division to indicate any change in the near future from the present treatment of syphilis. True, we hope that some day the treatment of syphilis may resolve itself even to one dose, but until Medical literature presents evidence of a preparation which is effective in fewer doses than those at present given, there will be no change in the policy of the Venereal Disease Division.

As to the R.T.C., for the past two years we have been struggling to acquire this property and to have the title vested in the name of the State Board of Health. We have only recently succeeded in attaining this goal. We certainly do not intend now that we have acquired the buildings to close them up and stop the program. We, therefore, do not contemplate any closure of the R.T.C., at the present time or in the near future. —R. W. Ball, M.D., Director, Division of Venereal Disease Control.

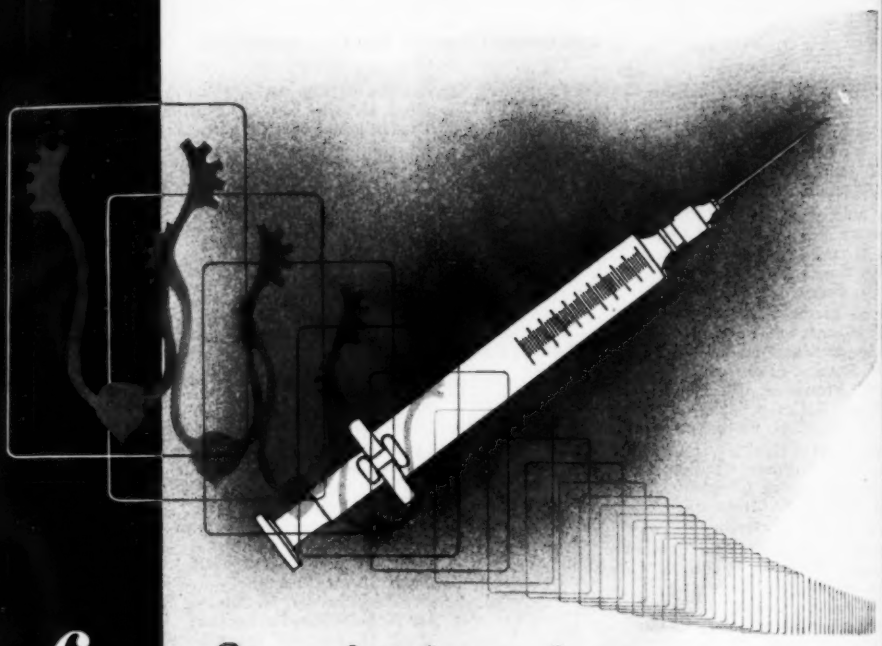
BIRTHS

Dr. and Mrs. Hervey W. Mead announce the birth of a son, Stanley Winthrop, August 16, in Columbia.

Dr. and Mrs. David Reese of Greenville, are being congratulated upon the birth of a daughter on August 7.

Dr. and Mrs. Robert S. Piper of Florence are being congratulated upon the birth of a daughter.

Announcement has been received of the birth of a daughter on September 22, to Dr. and Mrs. E. D. Guyton of Florence.



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(*disodium N-methyl-3,5-diiodo-chelidamate*)

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SCHERING

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Dr. A. E. Willis, Orangeburg
Dr. P. M. Temples, Spartanburg
Dr. W. S. Judy, Greenville
Dr. Ben Wyman, Columbia
Dr. T. A. Pitts, Columbia

DEATHS

JAMES NILES NESBITT

Dr. James Niles Nesbitt, 82, died at his home in Gaffney on August 29, after a long illness. A graduate of the University of Tennessee Medical College, Dr. Nesbitt had practiced medicine in Gaffney almost fifty years. He was an honorary member of the South Carolina Medical Association.

He is survived by one son and four daughters.

MARION RUDOLPH MOBLEY, JR.

Dr. Marion R. Mobley, Jr., died at a hospital in Florence on September 12 after an extended illness. Only twenty-six years of age at his death, Dr. Mobley received his education in the schools of Florence, Davidson College and Vanderbilt Medical College. He served his internship at Pittsburgh University Center and was a resident physician at Massachusetts Eye and Ear Infirmary, Boston. For the past year, when able to work, he had been associated with his father at the Mobley-Stokes Clinic.

He is survived by his widow and one daughter.

JOHN HENNING PORTER

Dr. John H. Porter, practicing physician of Andrews for more than twenty-five years, died at a hospital in Florence, September 17, after an illness of several weeks. He was 55 years old.

A native of Georgetown County he had been a member of the House of Representatives from that county for the past eighteen years.

Survivors include his widow, a stepson and two sisters.

AMBROSE MILLER WYLIE

Dr. Ambrose Miller Wylie, 73, died at his home in Chester, September 21, after an illness of almost a year. A native of Chester County, Dr. Wylie received his education in the schools of Chester County, Erskine College, and was graduated from the Medical College of the State of South Carolina in 1903. He had practiced medicine in Chester for more than forty-four years and was an honorary member of the South Carolina Medical Association.

He is survived by his widow, three sons and two daughters.

THE ATLANTA GRADUATE MEDICAL ASSEMBLY

announces its 1949 meeting

January 24, 25, 26

Among the speakers will be:

Dr. George C. Burch
Dr. Konrad E. Bloch
Dr. Henry L. Bockus
Dr. George Crile
Dr. Lester R. Dragstedt
Dr. Sidney Farber
Dr. E. C. Hamblen
Dr. Charles E. Irwin
Dr. Walter Kempner
Dr. Oswald S. Lowsley
Dr. W. F. Mengert
Dr. William C. Menninger
Dr. Rufus F. Payne
Dr. R. H. Smithwick
Dr. Everitt D. Sugarbaker
Dr. O. H. Wangensteen

Make your arrangements now to attend.

WOMAN'S AUXILIARY

SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. P. M. Temples Publicity Secretary: Mrs. William H. Folk

The Woman's Auxiliary to the South Carolina Medical Association shall miss our beloved member, Mrs. W. L. Pressly, Due West, South Carolina.

Dr. Pressly is on our Advisory Council and members of the Woman's Auxiliary to the South Carolina Medical Association wish to express our love and sympathy to you in your sorrow.

Mrs. Pressly was a member of the Woman's Auxiliary to the Third Medical District.

Members of the Woman's Auxiliary to the Greenville County Medical Society opened their fall work with a luncheon meeting September 6, 1948 at the Poinsett Hotel.

Dr. R. M. Pollitzer and Dr. T. G. Goldsmith, physicians on their Advisory Committee, were present to discuss auxiliary plans.

Mrs. Powell M. Temples, President, Woman's Auxiliary to the South Carolina Medical Association, Spartanburg, South Carolina, was guest speaker. Mrs. Temples spoke on phases of auxiliary work pointing out that "Increased Membership" and "Nurse Recruitment" should be stressed this year.

The Greenville Auxiliary presented Mrs. Temples with a beautiful French Antique China Celery Dish.

Mrs. William H. Folk, State Publicity Secretary, accompanied Mrs. Temples to the luncheon.

Mrs. Mordecai Nachman, Mrs. W. H. Lyday, and Mrs. J. E. Crosland were in charge of the luncheon.

Mrs. Lyday conducted several contests and prizes were donated by Greenville Merchants.

Each place was marked with place cards bearing the medical auxiliary emblem, and the Winchester-Ritch Surgical Company, Greensboro, N. C. gave each a finger nail file. Mrs. Everett B. Poole made the unique place cards.

Mrs. H. M. Whitworth, President of the Greenville Auxiliary, served as toastmistress. Mrs. Whitworth also presided at a short business session. The Greenville Auxiliary has a membership of sixty.

NEWS ITEMS

Dr. Walter E. Bryant, who has been associated with Dr. O. A. Alexander in Darlington, has joined the staff of the Johnson Memorial Hospital in Hemingway.

Dr. William Atmar Smith of Charleston delivered a talk at the Southern Tuberculosis conference in Savannah, September 30–October 2.

Dr. Homer S. Parnell is now associated with Drs. Charles N. Wyatt and Horace M. Whitworth and will limit his practice to surgery.

Dr. James B. Galloway of Bishopville was elected President of the Seventh District Medical Association at a recent meeting. Other officers elected were: Vice Presidents; Dr. Sedgwick Simons, Bishopville; Dr. A. C. Bozard, Manning; Dr. Michael Holmes, Kingstree; and Dr. Norman Eaddy, Sumter. Dr. W. E. Whitley, Andrews, and Dr. Carl B. Epps, Sumter, were elected secretary and treasurer.

Dr. E. Alex Heise, formerly health officer of Sumter County, is now medical director of the Southeastern area of the American Red Cross offices in Atlanta.

Dr. Robert S. Piper has opened offices in Florence for the practice of general medicine.

Dr. William H. Mathis, Jr., is now associated with Drs. Will S. Judy and Samuel H. Fisher in Greenville.

Dr. John M. Rhame has opened an office at Sumter for the practice of medicine and is the newest doctor to locate there.

Dr. Rhame is a native of Camden but has made his home here for the past eight years with Mr. and Mrs. E. Murr Hall, his uncle and aunt. He is a graduate of the Citadel and the Medical College of the State of South Carolina. His interneship was taken at Roper Hospital, Charleston. He served as captain in the medical corps for two years during the war.

Dr. Cliff Ratcliff, formerly of Anson County, N. C., has opened offices at 3911 Ensor Avenue in Eau Claire, as a general practitioner.

Doctor Ratcliff received his pre-medical training at Duke University in Durham, N. C. and his medical degree at the University of Maryland. His internships were served in Baltimore at the University Hospital and St. Agnes Hospital, and for two years he was in the Army Medical Corps at Staten Island Area Station Hospital, New York.

He and his wife and son are residing at 3903 Ensor Avenue, in Eau Claire.

SCHEDULE OF CANCER SEMINAR

The Cancer Seminar of the Southeastern States will be held on November 8, 9, and 10, 1948, at the Tampa Terrace Hotel, Tampa, Florida. The Seminar is under the direction of the Tumor Clinic, Tampa Municipal Hospital, Tampa, Florida, and is sponsored by the American Cancer Society, Florida Division, and the Florida State Board of Health.

The Cancer Seminar will consist of morning and afternoon sessions, presenting in panel discussion Carcinoma of the Breast, Carcinoma of the Lung, Carcinoma of the Uterus, Carcinoma of the Ovary, Carcinoma of the Stomach, and Lymphoblastoma-Leukemia.

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Each symposium will be discussed by a surgeon or internist, a pathologist, and a roentgenologist, who will handle the various phases of diagnosis, pathology, and treatment. At the end of each panel discussion, thirty minutes will be allowed for questions submitted by the audience.

This Seminar is conducted for the doctors of the Southeastern States and primarily intended for the benefit of physicians in the general practice of medicine; however, specialists in any field of medicine are urged to attend.

Requests for hotel accommodations should be sent to Mr. A. K. Dickinson, c/o Tampa Chamber of Commerce, Tampa, Florida, stating in your communication that you are attending the Cancer Seminar.

PROGRAM

Eleventh Annual Symposium
Duke University School of Medicine and Duke Hospital
Durham, North Carolina

November 4, 5, and 6, 1948

Thursday, November 4, 1948
2:00 P. M.

1. Dr. Harry Gold, New York, New York
   Newer Trends in the Management of Congestive Failure
2. Dr. Carl V. Moore, St. Louis, Missouri
   Recent Advances in the Treatment of Anemia
3. Dr. Harry L. Rogers, Philadelphia, Pennsylvania
   Recent Therapeutic Trends in Allergic Diseases

6:00 P. M.

Dinner at Hope Valley Country Club

8:00 P. M.

1. Dr. C. P. Rhoads, New York, New York
   Recent Advances in the Treatment of Malignant Neoplastic Disease
2. Dr. William L. Bradford, Rochester, New York
   Recent Developments in the Prevention and Treatment of Certain Communicable Diseases

Friday, November 5, 1948

10:00 A. M.

1. Dr. Wallace E. Herrell, Rochester, Minnesota
   The Present Status of Antibiotic Therapy
2. Dr. Stewart H. Clifford, Boston, Massachusetts
   The Prevention of Neonatal Mortailty

2:00 P. M.

1. Dr. Carl F. Schmidt, Philadelphia, Pennsylvania
   Newer Trends and Methods in the Development of Therapeutic Agents
2. Dr. Willard O. Thompson, Chicago, Illinois
   Therapeutic Advances in Endocrinology
3. Dr. Richard H. Freyberg, New York, New York
   The Treatment of Rheumatism and Allied Disorders

6:00 P. M.

Barbecue Supper

8:00-9:00 P. M.

Round Table Discussion—A question and answer program
Moderator—Dr. O. H. Perry Pepper, Philadelphia, Pennsylvania

Saturday, November 6, 1948

10:00 A. M.

1. Dr. J. E. Moore, Baltimore, Maryland
   The Treatment of Syphilis
2. Dr. Willis J. Potts, Chicago, Illinois
   Special Surgical Problems of Children

2:00 P. M.

Football Game—Duke University vs. Wake Forest College